HEALTH SCREENING FORM: UPDATED MARCH 24, 2020

Exposure Section:

1. Has anyone in the household been diagnosed with COVID-19.

   YES | NO If "YES," details:

2. Has anyone in the household been told to quarantine yourself by a public health authority?

   YES | NO If "YES," details:

3. Has anyone in the household been in close contact (less than 6 feet for a prolonged period of time) with someone who has tested positive for coronavirus disease 2019 (COVID-19)?

   YES | NO If "YES," details:

Travel History:

4. Has anyone in the household traveled anywhere internationally, including on a cruise, in the last 14 days?

   YES | NO If "YES," details:

5. Has anyone in the household traveled in the United States by airplane in the last 14 days?

   YES | NO If "YES," details:

Symptom History:

6. In the past 72 hours, has anyone in the household currently had:
   - ☐ Fever (temperature of 100.4 F or higher)
   - ☐ Cough
   - ☐ Shortness of breath or difficulty breathing
   - ☐ Body aches
   - ☐ Chills
   - ☐ Runny nose or stuffy nose
   - ☐ Sore throat
   - ☐ Diarrhea

   YES | NO If "YES," details: